STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: December 5, 6, 7, 8, 9, and 12, 2011 Facility number: 012329 Provider number: 155784 AIM number: 201002500 Survey team: Vicki Manuwal, RN TC Bobbie Costigan, RN Census bed type: SNF: 26 SNF/NF: 47 Total: 73 Census by payor type: Medicare: 26 Medicaid: 30 Other: 17 Total: 73 Sample: 15 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 12/19/11 Cathy Emswiller RN	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0167 SS=C	A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. Based on observation and interview, the facility failed to ensure the survey results were readily accessible to residents and guests without having to ask a staff member to retrieve the survey book. This deficient practice had the potential to affect 73 of 73 residents who reside in the facility. Findings include: Observation on 12/8/11 at 3:00 P.M., the survey book was unable to be located. During interview with the receptionist on 12/8/11 at 3:00 P.M., she retrieved the survey book from behind the receptionist desk. She further indicated the book is kept behind the desk and if someone wanted to see it, they were more than welcome to ask for it. Observation on 12/9/11 at 11:10 A.M., the survey book was once again located	F0167	F167It is the practice of this facility that a resident has the right to examine the results of the most recent survey.CORRECTIVE ACTION: The Survey Binder has been placed in the Library for easy access for Residents, Visitors, Staff, Etc.Notice posted at Reception area indicating that Survey Binder is located in Library.HOW OTHERS IDENTIFIED: Everyone wanting to view the binder will be addressed by placing the binder in the Library.PREVENTATIVE MEASURES: Administrator and/or designee will check placement of binder.MONITORING: Placement to be monitored daily for 2 weeks, 3 times a week for 8 weeks, weekly for 8 weeks, and monthly for 3 months. All findings will be reviewed at monthly QPI meeting.Any deficient practice will be addressed through staff education, in-service, and/or counseling.ADDENDUM ADDED: COMPLIANCE DATE CHANGED TO 1/9/12	01/09/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	behind the receptionist desk. During interview on 12/9/11 at 11:10 A.M., the receptionist indicated the survey book is normally kept behind the desk. A sign indicating the location of the survey book and results was not posted at any time during the above observations. 3.1-3(b)(1)			
F0223 SS=D	The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interview and record review, the facility failed to ensure residents were protected from verbal abuse by staff for 2 of 9 residents and that residents were protected from physical abuse from staff for 2 of 9 residents reviewed for abuse in a sample of 15. [CNA # 31 and CNA # 32] [Residents #40, #30] Findings include: 1. The clinical record of Resident #40 was reviewed on 12/06/2011 at 11:03 a.m. Resident #40's diagnoses include, but	F0223	F223It is the practice of this facility that residents will be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.CORRECTIVE ACTION: Resident # 40 - Resident is stable with no signs or symptoms of psychosocial issues related to this incident.Resident # 30 - Resident is stable with no signs or symptoms of psychosocial issues related to this incident.Employees involved in the incidents reviewed during survey have been terminated. Incidents were reported to ISDH, Ombudsman,	01/09/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	were not limited to, HTN (hypertension), COPD (Chronic Obstructive Pulmonary Disease) and right sided heart failure. A "Concern Report" dated 11/12/11 indicated, "...The first thing I heard this a.m. was Resident #40 telling me she does not want CNA #31 taking care of her, she said CNA #31 was rude to her one time. Later on Resident #30 was leaving the dining room and said she had to potty I don't want the other girl she slammed me down into my chair. After second shift came in another resident started saying she heard them in the bathroom (Resident #30 and the aid (sic)) and said Resident #30 was saying things like owe (sic), stop it that hurts, and she wished she could get out of that bed and go in there...." An unlabeled form dated 11/14/11 indicated, "Interview with Resident #40- Resident states that CNA #31 is very rude and she does not care for her. Resident further states that if CNA #31 answers her call light she instructs her to "go get someone to help me."...." An unlabeled form dated 11/18/11 at 4:00 p.m. indicated, "Employee stated she has never been abusive to a resident. She further stated that she was rushing a resident Sunday (11/13/11) to put her on the toilet and "flew out of the room" to		APS, and Law Enforcement as indicated. Facility will continue to follow Policy and Procedure related to Abuse Prohibition.HOW OTHERS IDENTIFIED: Residents residing in facility will be addressed by following Policy and Procedures and termination of employees involved.PREVENTATIVE MEASURES: Staff in-serviced on Abuse Prohibition Policy and Procedure to include proper reporting per policy.ADDENDUM ADDED 1/4/12MONITORING: Administrator and/or designee will continue to follow up on all allegations of abuse immediately. An Incident and Accident form will be completed on any allegation of abuse and will be followed up by Administrator and/or designee immediately per policy. All Incident and Accident forms are reviewed daily at morning meeting. Monitoring will continue on an indefinite basis per policy. All concern forms will continue to be reviewed daily. All findings will be reviewed at monthly QPI meeting.Any deficient practice will be addressed through staff education, in-service, and/or counseling.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	assist another resident who needed toileting...Employee stated that she doesn't say much to the residents because she does not want to be "stuck" in a resident's room talking to them...The employee stated she would "fight" this allegation because she has had her certification for 19 years and has not ever been rude or abusive to anyone. Employee further stated that she has never had an argument or altercation with employee, CNA #32. This employee stated that CNA #32 is very lazy and confrontational and she doesn't say 2 (sic) words to her unless she has to. The employee was not told the name of the employee with whom is was reported she had an altercation; (sic) yet, she knew with whom the confrontation was alleged to have taken place." The "Disciplinary Action Report" dated 11/14/11 for CNA #32 indicated, "...Specify work rule, policy, standard, ect., violated- Failure to report allegation of abuse to DON/Administrator. Describe what happened- On 11/14/11, ADON received concern report alleging another CNA was abusive to Resident #40 and Resident #30. DON and Administrator were notified. One employee (alleged abuser) is on vacation thru 11/18/11. This employee is suspended pending investigation...."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The "Disciplinary Action Report" dated 11/18/11 for CNA #32 indicated, "...Specify work rule, policy, standard, ect., violated- Violation of Abuse Policy- not reporting per policy. Use of profanity/altercation in Resident area. Described what happened- Residents alleged abuse to this employee who failed to notify HFA (Administrator)/DON; but instead, wrote a concern form which was reviewed 11/14/11. Employee engaged in altercation with another employee at nursing station which included profanity...Disciplinary action being taken:...Discharge from employment...." The "Disciplinary Action Report" dated 11/18/11 for CNA #31 indicated, "...Specify work rule, policy, standard, ect., violated- Violation of Abuse Policy. Describe what happened- Multiple residents alleged this employee was abusive. Investigation substantiated allegation of abuse. Employee had argument /altercation with another staff member at nurses station in front of residents and staff...Disciplinary action being taken:...Discharge from employment...11/18/11 employee refused to sign...(CNA #31) I do NOT AGREE WITH THIS, I HAVE NEVER ABUSED ANYONE. (CNA #31 signature)"			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2. The clinical record of Resident #30 was reviewed on 12/7/2011 at 12:55 p.m. Resident #30's diagnoses include, but were not limited to, HTN (hypertension) and CHF (congestive heart failure) A "Concern Report" dated 11/12/11 indicated, "...The first thing I heard this a.m. was Resident #40 telling me she does not want CNA #31 taking care of her, she said CNA #31 was rude to her one time. Later on Resident #30 was leaving the dining room and said she had to potty I don't want the other girl she slammed me down into my chair. After second shift came in another resident started saying she heard them in the bathroom (Resident #30 and the aid (sic)) and said Resident #30 was saying things like owe (sic), stop it that hurts, and she wished she could get out of that bed and go in there...." An unlabeled form dated 11/14/11 at 10:45 a.m. indicated, "Interview with Resident #30- Resident #30 stated that CNA #31 is rough and slammed her into her wheelchair after taking her to the bathroom before lunch on Saturday (11/12/11) and that she did not want her to take her to the bathroom ever again. She stated she doesn't want to get anyone in trouble but she does not want her helping her any more (sic)...."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	An unlabeled form dated 11/18/11 at 4:00 p.m. indicated, "Employee stated she has never been abusive to a resident. She further stated that she was rushing a resident Sunday (11/13/11) to put her on the toilet and "flew out of the room" to assist another resident who needed toileting...Employee stated that she doesn't say much to the residents because she does not want to be "stuck" in a resident's room talking to them...The employee stated she would "fight" this allegation because she has had her certification for 19 years and has not ever been rude or abusive to anyone. Employee further stated that she has never had an argument or altercation with employee, CNA #32. This employee stated that CNA #32 is very lazy and confrontational and she doesn't say 2 (sic) words to her unless she has to. The employee was not told the name of the employee with whom is was reported she had an altercation; (sic) yet, she knew with whom the confrontation was alleged to have taken place." The "Disciplinary Action Report" dated 11/14/11 for CNA #32 indicated, "...Specify work rule, policy, standard, ect., violated- Failure to report allegation of abuse to DON/Administrator. Describe what happened- On 11/14/11, ADON received concern report alleging another			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	CNA was abusive to Resident #40 and Resident #30. DON and Administrator were notified. One employee (alleged abuser) is on vacation thru 11/18/11. This employee is suspended pending investigation...." The "Disciplinary Action Report" dated 11/18/11 for CNA #32 indicated, "...Specify work rule, policy, standard, ect., violated- Violation of Abuse Policy- not reporting per policy. Use of profanity/altercation in Resident area. Described what happened- Residents alleged abuse to this employee who failed to notify HFA (Administrator)/DON; but instead, wrote a concern form which was reviewed 11/14/11. Employee engaged in altercation with another employee at nursing station which included profanity...Disciplinary action being taken:...Discharge from employment...." The "Disciplinary Action Report" dated 11/18/11 for CNA #31 indicated, "...Specify work rule, policy, standard, ect., violated- Violation of Abuse Policy. Describe what happened- Multiple residents alleged this employee was abusive. Investigation substantiated allegation of abuse. Employee had argument /altercation with another staff member at nurses station in front of residents and staff...Disciplinary action			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	being taken:...Discharge from employment...11/18/11 employee refused to sign...(CNA #31) I do NOT AGREE WITH THIS, I HAVE NEVER ABUSED ANYONE. (CNA #31 signature)" 3. The clinical record for Resident # 1 reviewed on 12/5/11 at 3:00 P.M., indicated diagnoses of, but not limited to: cerebrovascular accident, hemiplegia, and arthritis. Review of a "Facility Incident Reporting Form" indicated, "...Incident Date: 11/14/11...Resident, (Name), reported to a CNA (certified nursing aide) that she did not want the CNA (CNA # 31) who had cared for her during the day shift to care for her any more (sic). The resident stated that she did not like this CNA (CNA # 31) because she is very rude and rough with her. She further explained that (Name, CNA # 31) is always in a hurry when she dresses her and she pulls on her left arm which hurts her. The resident states that she has asked (Name, CNA # 31) to be gentile (sic) many times and that she ignores her and begins to sing songs. (Name, CNA # 31) alleges that when assisting the resident to stand, the CNA does not allow her to stand; but, she reaches under her arms and lifts her up and throws her in her chair....CNA (Name, CNA # 31) was immediately suspended pending investigation....The			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	allegation was substantiated and the CNA (CNA # 31) was terminated...." During interview with the Administrator and Director of Nursing on 12/6/11 at 6:10 P.M., they indicated they followed their facility policy regarding abuse and terminated the employee involved as the abuse was substantiated. Review of a facility policy titled "Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property", dated October 1999, revised last July 2010, indicated "...Extendicare Health Services, Inc. (EHSI) prohibits the mistreatment, neglect, and abuse of residents and misappropriation of resident property by anyone including staff, family, friends, etc....Verbal abuse is oral, written, or gestured language that includes disparaging and derogatory terms to the resident or their families or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability....Physical abuse includes hitting, slapping, pinching, scratching, spitting, holding roughly, etc...." 3.1-27(a)(1) 3.1-27(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to ensure the Administrator was immediately notified of an allegation of verbal abuse by staff for 1 of 9 residents reviewed for abuse in a sample	F0225	F225It is the practice of this facility that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident	01/09/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	of 15. [CNA # 31 and CNA # 32] [Resident # 30, # 40] Findings include: 1. The clinical record of Resident #40 was reviewed on 12/06/2011 at 11:03 a.m. Resident #40's diagnoses include, but were not limited to, HTN (hypertension), COPD (Chronic Obstructive Pulmonary Disease) and right sided heart failure. A "Concern Report" dated 11/12/11 indicated, "...The first thing I heard this a.m. was Resident #40 telling me she does not want CNA #31 taking care of her, she said CNA #31 was rude to her one time. Later on Resident #30 was leaving the dining room and said she had to potty I don't want the other girl she slammed me down into my chair. After second shift came in another resident started saying she heard them in the bathroom (Resident #30 and the aid (sic)) and said Resident #30 was saying things like owe (sic), stop it that hurts, and she wished she could get out of that bed and go in there...." An unlabeled form dated 11/14/11 indicated, "Interview with Resident #40- Resident states that CNA #31 is very rude and she does not care for her. Resident further states that if CNA #31 answers her call light she instructs her to "go get		property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including the State survey and certification agency).CORRECTIVE ACTION: ADDENDUM ADDED 1/4/12Resident # 40 - Resident is stable with no signs or symptoms of psychosocial issues related to this incident.Resident # 30 - Resident is stable with no signs or symptoms of psychosocial issues related to this incident.Employees involved in the incidents reviewed during survey have been terminated. Incidents were reported to ISDH, Ombudsman, APS, and Law enforcement as indicated. Facility will continue to follow Policy and Procedures related to Abuse Prohibition.HOW OTHERS IDENTIFIED: Residents residing in facility will be addressed by following Policy and Procedures and the termination of employees involved.PREVENTATIVE MEAURES: Staff in-serviced on Abuse Prohibition Policy and Procedure to include proper reporting per policy.MONITORING: Administrator and/or designee will continue to follow up on allegations of abuse immediately. Concern forms will continue to be reviewed daily. All findings will be reviewed at monthly QPI meeting.Any deficient practice will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	someone to help me."...." An unlabeled form dated 11/18/11 at 4:00 p.m. indicated, "Employee stated she has never been abusive to a resident. She further stated that she was rushing a resident Sunday (11/13/11) to put her on the toilet and "flew out of the room" to assist another resident who needed toileting...Employee stated that she doesn't say much to the residents because she does not want to be "stuck" in a resident's room talking to them...The employee stated she would "fight" this allegation because she has had her certification for 19 years and has not ever been rude or abusive to anyone. Employee further stated that she has never had an argument or altercation with employee, CNA #32. This employee stated that CNA #32 is very lazy and confrontational and she doesn't say 2 (sic) words to her unless she has to. The employee was not told the name of the employee with whom is was reported she had an altercation; (sic) yet, she knew with whom the confrontation was alleged to have taken place." The "Disciplinary Action Report" dated 11/14/11 for CNA #32 indicated, "...Specify work rule, policy, standard, ect., violated- Failure to report allegation of abuse to DON/Administrator. Describe		be addressed through staff education, in-service, and/or counseling.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	what happened- On 11/14/11, ADON received concern report alleging another CNA was abusive to Resident #40 and Resident #30. DON and Administrator were notified. One employee (alleged abuser) is on vacation thru 11/18/11. This employee is suspended pending investigation...." The "Disciplinary Action Report" dated 11/18/11 for CNA #32 indicated, "...Specify work rule, policy, standard, ect., violated- Violation of Abuse Policy- not reporting per policy. Use of profanity/altercation in Resident area. Described what happened- Residents alleged abuse to this employee who failed to notify HFA (Administrator)/DON; but instead, wrote a concern form which was reviewed 11/14/11. Employee engaged in altercation with another employee at nursing station which included profanity...Disciplinary action being taken:...Discharge from employment...." The "Disciplinary Action Report" dated 11/18/11 for CNA #31 indicated, "...Specify work rule, policy, standard, ect., violated- Violation of Abuse Policy. Describe what happened- Multiple residents alleged this employee was abusive. Investigation substantiated allegation of abuse. Employee had argument /altercation with another staff			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	member at nurses station in front of residents and staff...Disciplinary action being taken:...Discharge from employment...11/18/11 employee refused to sign...(CNA #31) I do NOT AGREE WITH THIS, I HAVE NEVER ABUSED ANYONE. (CNA #31 signature)" 2. The clinical record of Resident #30 was reviewed on 12/7/2011 at 12:55 p.m. Resident #30's diagnoses include, but were not limited to, HTN (hypertension) and CHF (congestive heart failure) A "Concern Report" dated 11/12/11 indicated, "...The first thing I heard this a.m. was Resident #40 telling me she does not want CNA #31 taking care of her, she said CNA #31 was rude to her one time. Later on Resident #30 was leaving the dining room and said she had to potty I don't want the other girl she slammed me down into my chair. After second shift came in another resident started saying she heard them in the bathroom (Resident #30 and the aid (sic)) and said Resident #30 was saying things like owe (sic), stop it that hurts, and she wished she could get out of that bed and go in there...." An unlabeled form dated 11/14/11 at 10:45 a.m. indicated, "Interview with Resident #30- Resident #30 stated that CNA #31 is rough and slammed her into			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	her wheelchair after taking her to the bathroom before lunch on Saturday (11/12/11) and that she did not want her to take her to the bathroom ever again. She stated she doesn't want to get anyone in trouble but she does not want her helping her any more (sic)...." An unlabeled form dated 11/18/11 at 4:00 p.m. indicated, "Employee stated she has never been abusive to a resident. She further stated that she was rushing a resident Sunday (11/13/11) to put her on the toilet and "flew out of the room" to assist another resident who needed toileting...Employee stated that she doesn't say much to the residents because she does not want to be "stuck" in a resident's room talking to them...The employee stated she would "fight" this allegation because she has had her certification for 19 years and has not ever been rude or abusive to anyone. Employee further stated that she has never had an argument or altercation with employee, CNA #32. This employee stated that CNA #32 is very lazy and confrontational and she doesn't say 2 (sic) words to her unless she has to. The employee was not told the name of the employee with whom is was reported she had an altercation; (sic) yet, she knew with whom the confrontation was alleged to have taken place."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The "Disciplinary Action Report" dated 11/14/11 for CNA #32 indicated, "...Specify work rule, policy, standard, ect., violated- Failure to report allegation of abuse to DON/Administrator. Describe what happened- On 11/14/11, ADON received concern report alleging another CNA was abusive to Resident #40 and Resident #30. DON and Administrator were notified. One employee (alleged abuser) is on vacation thru 11/18/11. This employee is suspended pending investigation...." The "Disciplinary Action Report" dated 11/18/11 for CNA #32 indicated, "...Specify work rule, policy, standard, ect., violated- Violation of Abuse Policy- not reporting per policy. Use of profanity/altercation in Resident area. Described what happened- Residents alleged abuse to this employee who failed to notify HFA (Administrator)/DON; but instead, wrote a concern form which was reviewed 11/14/11. Employee engaged in altercation with another employee at nursing station which included profanity...Disciplinary action being taken:...Discharge from employment...." The "Disciplinary Action Report" dated 11/18/11 for CNA #31 indicated, "...Specify work rule, policy, standard,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	ect., violated- Violation of Abuse Policy. Describe what happened- Multiple residents alleged this employee was abusive. Investigation substantiated allegation of abuse. Employee had argument /altercation with another staff member at nurses station in front of residents and staff...Disciplinary action being taken:...Discharge from employment...11/18/11 employee refused to sign...(CNA #31) I do NOT AGREE WITH THIS, I HAVE NEVER ABUSED ANYONE. (CNA #31 signature)" Review of a facility policy titled "Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property", dated October 1999, revised last July 2010, indicated "...Extend Health Services, Inc. (EHSI) prohibits the mistreatment, neglect, and abuse of residents and misappropriation of resident property by anyone including staff, family, friends, etc....EHSI requires facilities to report these alleged violations to the Administrator and DON/designee immediately. "Immediately" means as soon as possible, but ought not to exceed 24 hours after discovery of incident...The Administrator is responsible for the assurance of this policy....Verbal abuse is oral, written, or gestured language that			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	includes disparaging and derogatory terms to the resident or their families or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability....Physical abuse includes hitting, slapping, pinching, scratching, spitting, holding roughly, etc...." During interview with the facility Administrator on 12/6/11 at 6:15 P.M., the Administrator indicated staff were expected to follow the facility policy and procedure regarding reporting and investigating incidents involving residents. 3.1-28(b)(2) 3.1-28(c)			
F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review, the facility failed to ensure the administrator was	F0226	F226It is the practice of this facility to develop and implement written policies and procedures	01/09/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	immediately notified of an allegation of verbal abuse by staff for 1 of 9 residents reviewed for abuse in a sample of 15. [CNA # 31 and CNA # 32] [Resident # 30, # 40] Findings include: 1. The clinical record of Resident #40 was reviewed on 12/06/2011 at 11:03 a.m. Resident #40's diagnoses include, but were not limited to, HTN (hypertension), COPD (Chronic Obstructive Pulmonary Disease) and right sided heart failure. A "Concern Report" dated 11/12/11 indicated, "...The first thing I heard this a.m. was Resident #40 telling me she does not want CNA #31 taking care of her, she said CNA #31 was rude to her one time. Later on Resident #30 was leaving the dining room and said she had to potty I don't want the other girl she slammed me down into my chair. After second shift came in another resident started saying she heard them in the bathroom (Resident #30 and the aid (sic)) and said Resident #30 was saying things like owe (sic), stop it that hurts, and she wished she could get out of that bed and go in there...." An unlabeled form dated 11/14/11 indicated, "Interview with Resident #40- Resident states that CNA #31 is very rude		that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.CORRECTIVE ACTION:Resident # 40 - Resident is stable with no signs or symptoms of psychosocial issues related to this incident.Resident # 30 - Resident is stable with no signs or symptoms of psychosocial issues related to this incident.Employees involved in the incidents reviewed during survey have been terminated. Incidents were reported to ISDH, Ombudsman, APS, and Law Enforcement as indicated. Facility will continue to follow Policy and Procedures related to Abuse Prohibition.HOW OTHERS IDENTIFIED: Residents residing in facility will be addressed by following Policy and Procedures and termination of employees involved.PREVENTATIVE MEASURES: Staff in-serviced on Abuse Prohibition Policy and Procedure to include proper reporting per policy.ADDENDUM ADDED 1/4/12MONITORING: Administrator and/or designee will continue to follow up on allegations of abuse immediately. An Incident and Accident form will be completed on any allegation of abuse and will be followed up by Administrator and/or designee immediately per policy. All Incident and Accident forms are reviewed daily at morning meeting. Monitoring will continue	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and she does not care for her. Resident further states that if CNA #31 answers her call light she instructs her to "go get someone to help me."...." An unlabeled form dated 11/18/11 at 4:00 p.m. indicated, "Employee stated she has never been abusive to a resident. She further stated that she was rushing a resident Sunday (11/13/11) to put her on the toilet and "flew out of the room" to assist another resident who needed toileting...Employee stated that she doesn't say much to the residents because she does not want to be "stuck" in a resident's room talking to them...The employee stated she would "fight" this allegation because she has had her certification for 19 years and has not ever been rude or abusive to anyone. Employee further stated that she has never had an argument or altercation with employee, CNA #32. This employee stated that CNA #32 is very lazy and confrontational and she doesn't say 2 (sic) words to her unless she has to. The employee was not told the name of the employee with whom is was reported she had an altercation; (sic) yet, she knew with whom the confrontation was alleged to have taken place." The "Disciplinary Action Report" dated 11/14/11 for CNA #32 indicated,		on an indefinite basis per policy. Concern forms will continue to be reviewed daily. All findings will be reviewed at monthly QPI meeting.Any deficient practice will be addressed through staff education, in-service, and/or counseling.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	"...Specify work rule, policy, standard, ect., violated- Failure to report allegation of abuse to DON/Administrator. Describe what happened- On 11/14/11, ADON received concern report alleging another CNA was abusive to Resident #40 and Resident #30. DON and Administrator were notified. One employee (alleged abuser) is on vacation thru 11/18/11. This employee is suspended pending investigation...." The "Disciplinary Action Report" dated 11/18/11 for CNA #32 indicated, "...Specify work rule, policy, standard, ect., violated- Violation of Abuse Policy- not reporting per policy. Use of profanity/altercation in Resident area. Described what happened- Residents alleged abuse to this employee who failed to notify HFA (Administrator)/DON; but instead, wrote a concern form which was reviewed 11/14/11. Employee engaged in altercation with another employee at nursing station which included profanity...Disciplinary action being taken:...Discharge from employment...." The "Disciplinary Action Report" dated 11/18/11 for CNA #31 indicated, "...Specify work rule, policy, standard, ect., violated- Violation of Abuse Policy. Describe what happened- Multiple residents alleged this employee was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	abusive. Investigation substantiated allegation of abuse. Employee had argument /altercation with another staff member at nurses station in front of residents and staff...Disciplinary action being taken:...Discharge from employment...11/18/11 employee refused to sign...(CNA #31) I do NOT AGREE WITH THIS, I HAVE NEVER ABUSED ANYONE. (CNA #31 signature)" 2. The clinical record of Resident #30 was reviewed on 12/7/2011 at 12:55 p.m. Resident #30's diagnoses include, but were not limited to, HTN (hypertension) and CHF (congestive heart failure) A "Concern Report" dated 11/12/11 indicated, "...The first thing I heard this a.m. was Resident #40 telling me she does not want CNA #31 taking care of her, she said CNA #31 was rude to her one time. Later on Resident #30 was leaving the dining room and said she had to potty I don't want the other girl she slammed me down into my chair. After second shift came in another resident started saying she heard them in the bathroom (Resident #30 and the aid (sic)) and said Resident #30 was saying things like owe (sic), stop it that hurts, and she wished she could get out of that bed and go in there...." An unlabeled form dated 11/14/11 at			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	10:45 a.m. indicated, "Interview with Resident #30- Resident #30 stated that CNA #31 is rough and slammed her into her wheelchair after taking her to the bathroom before lunch on Saturday (11/12/11) and that she did not want her to take her to the bathroom ever again. She stated she doesn't want to get anyone in trouble but she does not want her helping her any more (sic)...." An unlabeled form dated 11/18/11 at 4:00 p.m. indicated, "Employee stated she has never been abusive to a resident. She further stated that she was rushing a resident Sunday (11/13/11) to put her on the toilet and "flew out of the room" to assist another resident who needed toileting...Employee stated that she doesn't say much to the residents because she does not want to be "stuck" in a resident's room talking to them...The employee stated she would "fight" this allegation because she has had her certification for 19 years and has not ever been rude or abusive to anyone. Employee further stated that she has never had an argument or altercation with employee, CNA #32. This employee stated that CNA #32 is very lazy and confrontational and she doesn't say 2 (sic) words to her unless she has to. The employee was not told the name of the employee with whom is was reported she			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	had an altercation; (sic) yet, she knew with whom the confrontation was alleged to have taken place." The "Disciplinary Action Report" dated 11/14/11 for CNA #32 indicated, "...Specify work rule, policy, standard, ect., violated- Failure to report allegation of abuse to DON/Administrator. Describe what happened- On 11/14/11, ADON received concern report alleging another CNA was abusive to Resident #40 and Resident #30. DON and Administrator were notified. One employee (alleged abuser) is on vacation thru 11/18/11. This employee is suspended pending investigation...." The "Disciplinary Action Report" dated 11/18/11 for CNA #32 indicated, "...Specify work rule, policy, standard, ect., violated- Violation of Abuse Policy- not reporting per policy. Use of profanity/altercation in Resident area. Described what happened- Residents alleged abuse to this employee who failed to notify HFA (Administrator)/DON; but instead, wrote a concern form which was reviewed 11/14/11. Employee engaged in altercation with another employee at nursing station which included profanity...Disciplinary action being taken:...Discharge from employment...."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The "Disciplinary Action Report" dated 11/18/11 for CNA #31 indicated, "...Specify work rule, policy, standard, ect., violated- Violation of Abuse Policy. Describe what happened- Multiple residents alleged this employee was abusive. Investigation substantiated allegation of abuse. Employee had argument /altercation with another staff member at nurses station in front of residents and staff...Disciplinary action being taken:...Discharge from employment...11/18/11 employee refused to sign...(CNA #31) I do NOT AGREE WITH THIS, I HAVE NEVER ABUSED ANYONE. (CNA #31 signature)" Review of a facility policy titled "Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property", dated October 1999, revised last July 2010, indicated "...Extend Health Services, Inc. (EHSI) prohibits the mistreatment, neglect, and abuse of residents and misappropriation of resident property by anyone including staff, family, friends, etc....EHSI requires facilities to report these alleged violations to the Administrator and DON/designee immediately. "Immediately" means as soon as possible, but ought not to exceed 24 hours after discovery of incident...The			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Administrator is responsible for the assurance of this policy....Verbal abuse is oral, written, or gestured language that includes disparaging and derogatory terms to the resident or their families or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability....Physical abuse includes hitting, slapping, pinching, scratching, spitting, holding roughly, etc...." During interview with the facility Administrator on 12/6/11 at 6:15 P.M., the Administrator indicated staff were expected to follow the facility policy and procedure regarding reporting and investigating incidents involving residents. 3.1-28(a)			
F0282 SS=E	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to ensure physician orders and plan of care were followed related to sliding scale insulin for 2 of 6 residents (Resident # 14, # 31) reviewed with	F0282	F282It is the practice of this facility that the services provided or arranged by the facility be provided by qualified persons in accordance with each written care plan.1. Resident # 31 - M.D. notified of the medication errors	01/09/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	sliding scale insulin and failed to follow physician orders for 4 of 13 residents (Resident # 1, # 23, # 40, # 46) reviewed with parameters (criteria used to evaluate the need of a medication) and failed to monitor weights as ordered for 1 of 8 residents (Resident # 23) reviewed with weight orders and failed to monitor oxygen levels for 1 of 13 residents (Resident # 46) reviewed for vital signs in a sample of 15. The facility failed to ensure physician orders and plan of care were followed for 6 of 15 residents reviewed for physician orders and care plans in a sample of 15. Findings include: 1. The clinical record for Resident # 31 reviewed on 12/8/11 at 10:50 A.M., indicated diagnoses of, but not limited to: diabetes mellitus, hypertension, and obesity. Review of a "Physician's Order" dated 1/24/11, indicated, "...Novolin R (insulin)...sliding scale; 150-200=2 units; 201-250=4 units; 251-300=6 units; 301-350=8 units; 351-400=10 units; > (greater than) or < (less than) 60=call MD; 7 A.M., 11:30 A.M., 4 P.M., 9 P.M...." Review of the October 1st through 17th		related to sliding scale discrepancies. No adverse reactions to medication errors.2. Resident # 14 - M.D. notified of the medication errors related to sliding scale discrepancies. No adverse reactions to medication errors.ADDENDUM ADDED 1/4/123. Resident # 1 - M.D. notified of error related to administration of Aranesp. Resident is stable. No adverse reaction from medication error. 4. Resident # 23 - Resident has discharged from the facility.5. Resident # 46 - Order for BIOX every shift has been discontinued.6. Resident # 40 - Resident is stable. Parameters for medication administration in place.Licensed nursing staff in-serviced on proper assessment, monitoring, and documentation related to following physician's orders related to parameters for monitoring medication administration, including but not limited to apical pulse, BIOX, accu check's, v/s, etc.HOW OTHERS IDENTIFIED: 100% audit of residents with physician's orders to assess, monitor, and document parameters related to medication administration, including but not limited to apical pulse, BIOX, accu check's, v/s, etc.ADDENDUM ADDED 1/4/12.PREVENTATIVE MEASURES: Residents with physician's orders with parameters for monitoring	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and 20th through 31st, 2011, MAR (Medication Administration Record), indicated incorrect sliding scale coverage for the following seven Accu Checks: 10/2/11 6:00 A.M. Accu Check 239 - 6 units given. Next available Accu Check 137 at 11:30 A.M. The clinical record indicated Resident # 31 should have received 4 units. 10/3/11 6:00 A.M. Accu Check 232 - 6 units given. Next available Accu Check 350 at 11:30 A.M. The clinical record indicated Resident # 31 should have received 4 units. 10/3/11 11:30 A.M. Accu Check 350 - 10 units given. Next available Accu Check 305 at 4:00 P.M. The clinical record indicated Resident # 31 should have received 8 units. 10/6/11 4:00 P.M. Accu Check 251 - 2 units given. Next available Accu Check 395 at 9:00 P.M. The clinical record indicated Resident # 31 should have received 6 units. 10/24/11 8:00 P.M. Accu Check 256 - 4 units given. Next available Accu Check 186 at 6:00 A.M. on 10/25/11. The clinical record indicated Resident # 31 should have received 6 units.		medication administration will have their MAR's monitored to ensure that proper parameters are being followed related to medication adminsitration. All finidngs will be recorded on the Clinical Monitoring Tool by Unit Manager's and/or designee and will be tracked until follow up is completed. Any errors or discrepancies will be addressed and follow up will be made to ensure physician notification and proper interventions are in place.ADDENDUM ADDED 1/4/12MONITORING: Unit Managers will monitor Clinical Monitoring Tool and resident's MAR's with parameters daily for 2 weeks, 3 times a week for 8 weeks, weekly for 8 weeks, and monthly for 3 months. All finding will be reviewed at monthly QPI meeting.Any deficient practice will be addressed through staff education, in-service, and/or counseling.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

10/25/11 8:00 P.M. Accu Check 371 - 6 units given. Next available Accu Check 182 at 6:00 A.M. on 10/26/11. The clinical record indicated Resident # 31 should have received 10 units.

10/30/11 8:00 P.M. Accu Check 359 - 6 units given. Next available Accu Check 333 at 6:00 A.M. on 10/31/11. The clinical record indicated Resident # 31 should have received 10 units.

Review of the November, 2011, MAR, indicated incorrect sliding scale coverage for the following three Accu Checks:

11/7/11 6:00 A.M. Accu Check 224 - 2 units given. Next available Accu Check 250 at 11:30 A.M. The clinical record indicated Resident # 31 should have received 4 units.

11/19/11 11:30 A.M. Accu Check 310 - 6 units given. Next available Accu Check 348 at 4:00 P.M. The clinical record indicated Resident # 31 should have received 8 units.

11/24/11 8:00 P.M. Accu Check 300 - 2 units given. Next available Accu Check 300 at 6:00 A.M. on 11/25/11. The clinical record indicated Resident # 31 should have received 6 units.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of the "Diabetes Plan of Care" dated 5/11, updated last 11/3/11, indicated, "...Administer insulin per MD order..." The clinical record lacked documentation of any medication errors related to incorrect dosage. During interview on 12/9/11 at 10:00 A.M., the ADON (Assistant Director of Nursing) indicated the unit managers are responsible for doing the audits of the sliding scale coverages to identify any errors. She further indicated if the unit managers did identify any errors, the physician notification of those errors would be documented in the nursing notes. Interview with the ADON on 12/9/11 at 11:45 A.M., she indicated the clinical record lacked documentation of sliding scale errors. 2. The clinical record for Resident # 14 reviewed on 12/6/11 at 10:15 A.M., indicated diagnoses of, but not limited to: diabetes mellitus, hypertension, and hyperlipidemia. Review of a "Physician's Order" dated 9/15/11, indicated, "...Novolog (insulin)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	sliding scale...AC (before meals) & HS (bedtime), < 150=0 units; 151-175=1 unit; 176-200=2 units; 201-225=3 units; 226-250=4 units; 251-275=5 units; 276-300=6 units; 301-325=7 units; 326-350=8 units; 351-375=9 units; 376-400=10 units; > 400=call doctor..." Review of the October 2011, MAR, indicated incorrect sliding scale coverage for the following four Accu Checks: 10/10/11 8:00 P.M. Accu Check 208 - 2 units given. Next available Accu Check 334 at 7:00 A.M. on 10/11/11. The clinical record indicated Resident # 31 should have received 3 units. 10/11/11 7:00 A.M. Accu Check 334 - 7 units given. Next available Accu Check 221 at 11:00 A.M. The clinical record indicated Resident # 14 should have received 8 units. 10/24/11 7:00 A.M. Accu Check 259 - 3 units given. Next available Accu Check 215 at 11:00 A.M. The clinical record indicated Resident # 14 should have received 5 units. 10/29/11 8:00 P.M. Accu Check 252 - 3 units given. Next available Accu Check 112 at 7:00 A.M. on 10/30/11. The clinical record indicated Resident # 14			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	should have received 5 units. Review of the November 2011, MAR, indicated incorrect sliding scale coverage for the following three Accu Checks: 11/1/11 8:00 P.M. Accu Check 198 - 1 units given. Next available Accu Check 204 at 7:00 A.M. on 11/2/11. The clinical record indicated Resident # 14 should have received 2 units. 11/8/11 7:00 A.M. Accu Check 230 - 3 units given. Next available Accu Check 183 at 11:00 A.M. The clinical record indicated Resident # 14 should have received 4 units. 11/1/11 4:00 P.M. Accu Check 368 - 8 units given. Next available Accu Check 201 at 8:00 P.M. The clinical record indicated Resident # 14 should have received 9 units. Review of the "Diabetes Plan of Care" dated 9/16, updated last 12/5/11, indicated, "...Administer insulin per MD order..." The clinical record lacked documentation of any medication errors related to incorrect dosage. During interview on 12/12/11 at 9:30			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A.M., the ADON indicated the facility did a 100 % audit of the sliding scale blood sugars when it was identified during the survey that there was still an issue with sliding scale errors. She further indicated the facility system that was in place was broken and didn't fully identify the problems. 3. The clinical record for Resident # 1 reviewed on 12/5/11 at 3:00 P.M., indicated diagnoses of, but not limited to: anemia,hemiplegia, and arthritis. Review of a "Physician's Order" dated 10/19/11, indicated, "...Aranesp (medication used to treat anemia - a low hemoglobin level) 60 mcg (micrograms)/0.3 ml (milliliters)...inject 0.3 ml sub q (injection) every week if HGB (hemoglobin) < 10..." Review of the November 2011, MAR, indicated Resident # 1's 11/25/11 Hemoglobin was 10.0. The MAR further indicated Resident # 1 received an Aranesp injection on 11/25/11. During interview with the ADON on 12/5/11 at 4:00 P.M., she indicated Resident # 1 did receive an Aranesp injection on 11/25/11. She further indicated Resident # 1 should not have received the injection based on the order			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	because her Hemoglobin level was not less than 10.0. 4. The clinical record for Resident # 23, reviewed on 12/5/11 at 4:10 P.M., indicated diagnoses of, but not limited to: atrial fibrillation, hypertension, and congestive heart failure. Review of a Physician Order, dated 11/23/11, indicated, "...Digoxin 0.125 mg (milligrams) po (orally) daily...8 A.M...." Review of the November 23rd through 30th, 2011, Medication Administration Record (MAR) indicated the following three days that lacked apical pulse monitoring: 11/26/11 11/27/11 11/30/11 Review of the December 1st through 5th, 2011, MAR indicated the following three days that lacked apical pulse monitoring: 12/1/11 12/3/11 12/4/11 The clinical record lacked documentation of the apical pulse related to digoxin administration.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

The 2010 Nursing Spectrum Drug Handbook, indicated, "...digoxin...Assess apical pulse regularly for 1 full minute. If rate is less than 60 beats/minute, withhold dose and notify prescriber..."

Review of the 11/23/11 through 11/30/11 "Physician's Orders" indicated, "...Daily Weight x (times) 3, 11/23, 11/24, 11/25; Weekly Weight x 4, then monthly, 11/30, 12/7, 12/14, 12/21..."

Review of a "Weights Detail Report" indicated weights for Resident # 23 done on 11/30/11 and 12/6/11.

The clinical record lacked documentation of weights on 11/23/11, 11/24/11, and 11/25/11.

Review of a "Quality Performance Improvement (QPI) Meeting" form received on 12/7/11 at 2:30 P.M., indicated, "...Meeting...held on November 18, 2011...The Care Tracker (computerized charting) weights are not matching the manual tracking system...."

During interview with the ADON on indicated the facility discussed the weight concerns during the QPI meeting on 11/18/11.

5. The clinical record of Resident #46

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was reviewed on 12/05/2011 at 3:04 p.m. Resident #46's diagnoses include, but were not limited to, hypertension and COPD (Chronic Obstructive Pulmonary Disease). A "Physician's Order" dated 10/12/11 through 10/31/11, indicated, "...BIOX (oxygen level) every shift and record. BIOX PRN & record...." A "Physician's Order" dated 10/27/11 through 10/31/11, indicated, "...BIOX every shift and record. BIOX PRN & record...." A "Physician's Order" dated 11/11/11 through 11/30/11, indicated, "...BIOX every shift and record. BIOX PRN & record...." A "Physician's Order" dated 12/01/11 through 12/31/11, indicated, "...BIOX every shift and record. BIOX PRN & record...." A review of the "Vital Signs-Individual Resident Flowsheet" dated from 10/13/11 through 12/5/11 indicated: October From 10/12/11 through 10/23/11 the biox was missed on 19 shifts. Resident #46 was discharged to the hospital from 10/23/11 through 10/27/11.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	From 10/27/11 through 10/31/11 the biox was missed on 10 shifts. Total shifts that missed completing the biox for October was 29. November From 11/1/11 through 11/2/11 the biox was missed on 2 shifts. Resident #46 was discharged to the hospital from 11/2/11 through 11/11/11 From 11/11/11 through 11/30/11 the biox was missed on 50 shifts. Total shifts that missed completing the biox for November was 52. December From 12/1/11 through 12/5/11 the biox was missed on 15 shifts. Total shifts that missed completing the biox for December was 15. A review of the "Nursing Notes" dated from 10/13/11 through 12/5/11 indicated the biox was documented on the missing dates as follows: October: 10 additional shifts not included in the "Vital Signs-Individual Resident Flowsheet." November: 6 additional shifts not included in the "Vital Signs-Individual Resident Flowsheet." December: 1 additional shift not included in the "Vital Signs-Individual Resident Flowsheet." During and interview with the ADON			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(Assistant Director of Nursing) 12/5/11 at 4:00 p.m. she indicated that the vital signs should be found in the "Vital Signs-Individual Resident Flowsheet" and possibly the "Nursing Notes." She also indicated that if they were not documented in either of those locations she would assume they were not completed. The "Medication Administration Record" indicated "...Hydralazine 50 mg(milligram)/tabs Give ii (two) tabs = 100 mg total dose po (by mouth) Q6 (every 6 hours) *Hold for SBP (systolic blood pressure) <140 HTN (hypertension) 10-12-11...." The following dates indicated the SBP was <140 and Hydralazine was administered: On 10/14/11 the blood pressure was 138/76 and signed off as given at 12:00 p.m. On 10/15/11 the blood pressure was 138/70 and signed off as given at 12:00 p.m. On 10/17/11 the systolic blood pressure was 120 and signed off as given at 6:00 p.m. On 10/21/11 the blood pressure was 133/60 and signed off as given at 12:00 p.m. 6. The clinical record of Resident #40 was reviewed on 12/06/2011 at 11:03 a.m.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident #40's diagnoses include, but were not limited to, HTN (hypertension), COPD (Chronic Obstructive Pulmonary Disease) and right sided heart failure. The "SBAR" (Situation/Background/Assessment/Request) form dated 11/1/11 at 3:00 p.m. indicated, "...The problem/symptom I am calling about if HTN, new admit...Primary diagnosis and/or reason resident is at the nursing home- Stage III decub (pressure sore), HTN, COPD. Pertinent medical history/include...SOB (shortness of breath)...Medication changes of new orders in the last two weeks- New admit... (For LPNs): The patient appears- upset states has been on Atenolol 100 mg BID (twice a day) + (and) Quinapril 20 mg QD (daily) for a long time. Hospital D/C (discharged) her to us w/o (without) BP (blood pressure) meds. Wants these started. Ok to order?...Reported to: Dr. (Name) MD Date: 11/1/11 Time: 3 pm. If to MD/NP/PA, communicated by:...Fax...." An unlabeled form indicated a fax date of 11/9/11 sent to Dr. (Name) regarding Resident #40 indicated, "...B/P 212/97 on 11/7/11...BP 179/84 on 11/8/11. Patients states B/P has been high since BP med was D/C. It was D/C in hospital on 10/31/11. She was on atenolol i (one) tab			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	25 mg/day...." The "Vital Signs-Individual Resident Flowsheet" for 10/31/11 through 12/5/11 indicated the following blood pressures: On 10/31/11 at 5:30 p.m. a blood pressure of 169/63. On 11/3/11 at 8:00 a.m. a blood pressure of 180/67. On 11/6/11 at 8:00 a.m. a blood pressure of 163/67. On 11/7/11 at 8:00 a.m. a blood pressure of 177/84. On 11/8/11 at 8:00 a.m. a blood pressure of 184/94. On 11/9/11 at 8:00 a.m. a blood pressure of 162/86. A "Physician Order" dated 11/09/11 indicated, "...Atenolol 25 mg tablet...Give 1 tablet orally once a day...." A "Physician Order" dated 12/02/11 indicated, "...hold Atenolol is SBP <110...." The "Vital Signs-Individual Resident Flowsheet" dated 12/2/11 indicated the blood pressure was 106/60. The "Medication Administration Record" dated 12/2/11 indicated the Atenolol was given. The "Vital Signs-Individual Resident			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Flowsheet" dated 12/3/11 indicated the blood pressure was 105/66. The "Medication Administration Record" dated 12/3/11 indicated the Atenolol was given. 3.1-35(g)(2)			
F0309 SS=D	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to provide the necessary pain medication to control a resident's pain for 1 of 9 residents reviewed for pain in a sample of 15. [Resident #40] Findings include: The clinical record of Resident #40 was reviewed on 12/06/2011 at 11:03 a.m. Resident #40's diagnoses include, but were not limited to, HTN (hypertension), COPD (Chronic Obstructive Pulmonary Disease), right sided heart failure, infected Stage III and unstageable pressure sores, rhadomyolysis, and chronic Cor Pulmonale.	F0309	F309It is the practice of this facility that each resident receives and the facility provides the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, comprehensive assessment and plan of care.CORRECTIVE ACTION: Resident # 40 - Resident has current order for routine and prn pain medication.Written notice sent to physician/Medical Director regarding responsibilities for pain management of residents. In the event the nursing staff get an inappropriate response from physician related to resident orders the nurse is to call Administrator and/or D.O.N. immediately. Administrator and/or D.O.N. will contact	01/09/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A "Physician's Orders" dated 10/31/11 indicated, "...Hydrocodone-APAP 5-325 Take 2 PO (by mouth) Q6 (every 6 hours) for pain PRN (as needed)...." The "Medication Administration Record" dated 11/1/11 through 11/10/11 indicated Resident #40 requested the hydrocodone-APAP PRN medication 22 times out of an available 40 doses. A "Physician's Orders" dated 11/11/11 indicated, "...Hydrocodone APAP 5-325 mg IC: Norco 5-325 Tablet...Give 2 tablets orally every 6 hours as needed for pain...." The "Medication Administration Record" dated 11/11/11 through 11/24/11 indicated Resident #40 requested the hydrocodone-APAP PRN medication 35 times out of an available 56 doses. A "Physician's Orders" dated 11/22/11 indicated a change from PRN (as needed) to a scheduled routine order, "...Hydrocodone 5/325 2 po (by mouth) q6 (every 6 hours)...." On the back of the "Medication Administration Record" in the "Nurses PRN Notes" dated 11/29/11 at 6 p.m. "...Norco 5-325 out of stock and no order to get in EDK due to no faxed signature		physician/Medical Director. In the event Adminstrator and/or D.O.N. are unable to get resolution the resident will be sent to the E.R. for evaluation and treatment.HOW OTHERS IDENTIFIED: Residents residing in the facilty will be addressed by notification sent to physician/Medical Director.PREVENTATIVE MEASURES: A.D.O.N. and/or designee will review prn medication logs on Thursday of each week to check the current availability and the amount of medication on hand against the possible need and will obtain order from physician on Fridays during rounds to prevent exhausting supply on weekends.MONITORING: A.D.O.N. and/or designee will monitor the pain medication logs to ensure medication is available. Medication logs will be monitored daily for 2 weeks, 3 times a week for 8 weeks, weekly for 8 weeks, and monthly for 3 months. All findings will be reviewed at monthly QPI meeting.Any deficient practice will be addressed through staff education, in-service, and/or counseling.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	for Dr. (Name)...." On the back of the "Medication Administration Record" in the "Nurses PRN Notes" dated 11/30/11 at 12 a.m. "...Vicodin not available...." The "Medication Administration Record" dated 11/30/11 indicated the next dose of Hydrocodone APAP 5-325 was given at 12:00 p.m. A "Nursing Note" dated 11/29/11 at 6:00 p.m. indicated, "No Norco in stock for resident. Called (Pharmacy Name). They stated they faxed two papers to Dr. (Name)'s office to get a signed order but no response from him." A "Nursing Note" dated 11/29/11 at 7:00 p.m. indicated, "Phoned Dr. (Name) asked him for an order for Norco he stated "no he was not doing it tonight" I stated resident was completely out of pain meds. He said it will wait until morning. I then informed resident." During an interview on 12/5/11 at 5:00 p.m. with Unit Manager #28 she indicated that according to the "Medication Administration Record," Resident #40 was out of her pain medication, Hydrocodone APAP 5-325, from 11/29/11 at 12:00 p.m. until 11/30/11 at			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	6:00 p.m. for approximately 30 hours. During an interview with Resident #40 on 12/6/11 at 4:35 p.m. she indicated that she was concerned about getting medication refills from her physician while in the facility. She indicated that this is not the first time she has had to wait over 24 for a refill on a medication at this facility. She specifically remembers this time due to it being her pain medication. She indicated that she did take her PRN (as needed) medication, Tylenol, but felt that she has better pain control when she had her Norco. She included that she is upset due to Social Services telling her that her expectations of her physician were not reasonable. 3.1-37(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0329 SS=D	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on interview and record review, the facility failed to ensure residents were free of unnecessary medications by failing to monitor vital signs for 2 of 13 residents reviewed with parameters (criteria used to evaluate the need for medications) in a sample of 15. [Resident # 23, # 46] Findings include: 1. The clinical record for Resident # 23, reviewed on 12/5/11 at 4:10 P.M., indicated diagnoses of, but not limited to: atrial fibrillation, hypertension, and congestive heart failure.	F0329	F329It is the practice of this facility that each residents drug regimen is free from unnecessary drugs.CORRECTIVE ACTION: 1. Resident # 23 - Resident has been discharged from facility.ADDENDUM ADDED 1/4/122. Resident # 46 - M.D. notified related to obtain BIOX every shift. Resident is stable. Order for BIOX every shift has been discontinued.Licensed nursing staff in-serviced on proper assessment, monitoring, and documentation related to following physician's orders related to parameters for monitoring medication administration, including but not limited to apical pulse, BIOX,	01/09/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of a Physician Order, dated 11/23/11, indicated, "...Digoxin 0.125 mg (milligrams) po (orally) daily...8 A.M...." Review of the November 23rd through 30th, 2011, Medication Administration Record (MAR) indicated the following three days that lacked apical pulse monitoring: 11/26/11 11/27/11 11/30/11 Review of the December 1st through 5th, 2011, MAR indicated the following three days that lacked apical pulse monitoring: 12/1/11 12/3/11 12/4/11 The clinical record lacked documentation of the apical pulse related to digoxin administration. Review of a "Cardiovascular/Circulatory: Plan of Care" dated 11/24/11, indicated, "...Meds/Tx (treatment) as ordered...Monitor for sign/symptoms of cardiac distress..." During interview with the ADON on		accu check's, v/s, etc.HOW OTHERS IDENTIFIED: 100 % audit of residents with physician's orders to assess, monitor, and document parameters related to medication administration, including but not limtied to apical pulse, BIOX, accu check's, v/s, etc.ADDENDUM ADDED 1/4/12PREVENTATIVE MEASURES: Residents with physician's orders with parameters for monitoring medication administration will have their MAR's monitored to ensure that proper parameters are being followed related to the medication administration. Findings will be recorded on Clinical Monitoring Tool and tracked until follow up is completed by Unit Manager. Any errors or discrepancies will be addressed and follow up will be made to ensure physician notification and proper interventions are in place.ADDENDUM ADDED 1/4/12MONITORING: Unit Managers will monitor Clinical Monitoring Tool and the residents MAR's with parameters daily for 2 weeks, 3 times a week for 8 weeks, weekly for 8 weeks, and monthly for 3 months. Findings will be reivewed at monthly QPI meeting.Any deficient practice will be addressed through staff education, in-service, and/or counseling.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	12/12/11 at 9:45 A.M., she indicated the apical pulse would either be documented on the MAR of the vital sign sheet. The 2010 Nursing Spectrum Drug Handbook, indicated, "...digoxin...Assess apical pulse regularly for 1 full minute. If rate is less than 60 beats/minute, withhold dose and notify prescriber..." 2. The clinical record of Resident #46 was reviewed on 12/05/2011 at 3:04 p.m. Resident #46's diagnoses include, but were not limited to, hypertension and COPD (Chronic Obstructive Pulmonary Disease). A "Physician Order" dated 11/09/11 indicated, "...Atenolol 25 mg tablet...Give 1 tablet orally once a day...." A "Physician Order" dated 12/02/11 indicated, "...hold Atenolol is SBP <110...." The "Vital Signs-Individual Resident Flowsheet" dated 12/2/11 indicated the blood pressure was 106/60. The "Medication Administration Record" dated 12/2/11 indicated the Atenolol was given. The "Vital Signs-Individual Resident Flowsheet" dated 12/3/11 indicated the blood pressure was 105/66. The			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	"Medication Administration Record" dated 12/3/11 indicated the Atenolol was given. 3.1-48(a)(6)			
F0333 SS=D	The facility must ensure that residents are free of any significant medication errors. Based on interview and record review, the facility failed to ensure 3 of 15 residents reviewed with medication orders were free of significant medication orders in a sample of 15. [Residents # 1, # 14, # 31] Findings include: 1. The clinical record for Resident # 31 reviewed on 12/8/11 at 10:50 A.M., indicated diagnoses of, but not limited to: diabetes mellitus, hypertension, and obesity. Review of a "Physician's Order" dated 1/24/11, indicated, "...Novolin R (insulin)...sliding scale; 150-200=2 units; 201-250=4 units; 251-300=6 units; 301-350=8 units; 351-400=10 units; > (greater than) or < (less than) 60=call MD; 7 A.M., 11:30 A.M., 4 P.M., 9 P.M...."	F0333	F333It is the practice of this facility that residents are free of significant medication errors.CORRECTIVE ACTION:ADDENDUM ADDED 1/4/121. Resident # 1 - M.D. notified of error related to administration of Aranesp. Resident is stable. No adverse reaction from medication error.2. Resident # 14 - M.D. notified of medication errors related to sliding scale discrepancies. No adverse reaction to medication errrors.3. Resident # 31 - M.D. notified of medicaiton errors related to sliding scale discrepancies. No adverse reaction to medication errors. Licensed nursing staff in-serviced on proper assessment, monitoring, and documentation related to following physician's orders related to parameters for monitoring medication administration, including but not limited to apical pulse, BIOX, accu check's, v/s, etc.HOW OTHERS IDENTIFIED: 100 %	01/09/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of the October 1st through 17th and 20th through 31st, 2011, MAR (Medication Administration Record), indicated incorrect sliding scale coverage for the following seven Accu Checks: 10/3/11 6:00 A.M. Accu Check 232 - 6 units given. Next available Accu Check 350 at 11:30 A.M. The clinical record indicated Resident # 31 should have received 4 units. 10/3/11 11:30 A.M. Accu Check 350 - 10 units given. Next available Accu Check 305 at 4:00 P.M. The clinical record indicated Resident # 31 should have received 8 units. 10/6/11 4:00 P.M. Accu Check 251 - 2 units given. Next available Accu Check 395 at 9:00 P.M. The clinical record indicated Resident # 31 should have received 6 units. 10/24/11 8:00 P.M. Accu Check 256 - 4 units given. Next available Accu Check 186 at 6:00 A.M. on 10/25/11. The clinical record indicated Resident # 31 should have received 6 units. 10/25/11 8:00 P.M. Accu Check 371 - 6 units given. Next available Accu Check 182 at 6:00 A.M. on 10/26/11. The		audit of residents with physician's orders to assess, monitor, and document parameters related to medication administration, including but not limtied to apical pulse, BIOX, accu check's, v/s, etc.PREVENTATIVE MEASURES: Residents with physician's orders with parameters for monitoring medication administration will have their MAR's monitored to ensure that proper parameters are being followed related to the medication administration. Findings will be recorded on Clinical Monitoring Tool and tracked until follow up is completed. Any errors or discrepancies will be addressed and follow up will be made to ensure physician notification and proper interventions are in place.ADDENDUM ADDED 1/4/12MONITORING: Unit Managers will monitor the Clinical Monitoring Toola and residents MAR's with parameters daily for 2 weeks, 3 times a week for 8 weeks, weekly for 8 weeks, and monthly for 3 months. Findings will be reivewed at monthly QPI meeting.Any deficient practice will be addressed through staff education, in-service, and/or counseling.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	clinical record indicated Resident # 31 should have received 10 units. 10/30/11 8:00 P.M. Accu Check 359 - 6 units given. Next available Accu Check 333 at 6:00 A.M. on 10/31/11. The clinical record indicated Resident # 31 should have received 10 units. Review of the November, 2011, MAR, indicated incorrect sliding scale coverage for the following three Accu Checks: 11/7/11 6:00 A.M. Accu Check 224 - 2 units given. Next available Accu Check 250 at 11:30 A.M. The clinical record indicated Resident # 31 should have received 4 units. 11/19/11 11:30 A.M. Accu Check 310 - 6 units given. Next available Accu Check 348 at 4:00 P.M. The clinical record indicated Resident # 31 should have received 8 units. 11/24/11 8:00 P.M. Accu Check 300 - 2 units given. Next available Accu Check 300 at 6:00 A.M. on 11/25/11. The clinical record indicated Resident # 31 should have received 6 units. Review of the "Diabetes Plan of Care" dated 5/11, updated last 11/3/11, indicated, "...Administer insulin per MD			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	order..." During interview on 12/9/11 at 10:00 A.M., the ADON (Assistant Director of Nursing) indicated the unit managers are responsible for doing the audits of the sliding scale coverages to identify any errors. She further indicated if the unit managers did identify any errors, the physician notification of those errors would be documented in the nursing notes. 2. The clinical record for Resident # 14 reviewed on 12/6/11 at 10:15 A.M., indicated diagnoses of, but not limited to: diabetes mellitus, hypertension, and hyperlipidemia. Review of a "Physician's Order" dated 9/15/11, indicated, "...Novolog (insulin) sliding scale...AC (before meals) & HS (bedtime), < 150=0 units; 151-175=1 unit; 176-200=2 units; 201-225=3 units; 226-250=4 units; 251-275=5 units; 276-300=6 units; 301-325=7 units; 326-350=8 units; 351-375=9 units; 376-400=10 units; > 400=call doctor..." Review of the October 2011, MAR, indicated incorrect sliding scale coverage for the following four Accu Checks: 10/10/11 8:00 P.M. Accu Check 208 - 2			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	units given. Next available Accu Check 334 at 7:00 A.M. on 10/11/11. The clinical record indicated Resident # 14 should have received 3 units. 10/11/11 7:00 A.M. Accu Check 334 - 7 units given. Next available Accu Check 221 at 11:00 A.M. The clinical record indicated Resident # 14 should have received 8 units. 10/24/11 7:00 A.M. Accu Check 259 - 3 units given. Next available Accu Check 215 at 11:00 A.M. The clinical record indicated Resident # 14 should have received 5 units. 10/29/11 8:00 P.M. Accu Check 252 - 3 units given. Next available Accu Check 112 at 7:00 A.M. on 10/30/11. The clinical record indicated Resident # 14 should have received 5 units. Review of the November 2011, MAR, indicated incorrect sliding scale coverage for the following three Accu Checks: 11/1/11 8:00 P.M. Accu Check 198 - 1 units given. Next available Accu Check 204 at 7:00 A.M. on 11/2/11. The clinical record indicated Resident # 14 should have received 2 units. 11/8/11 7:00 A.M. Accu Check 230 - 3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	units given. Next available Accu Check 183 at 11:00 A.M. The clinical record indicated Resident # 14 should have received 4 units. 11/1/11 4:00 P.M. Accu Check 368 - 8 units given. Next available Accu Check 201 at 8:00 P.M. The clinical record indicated Resident # 14 should have received 9 units. Review of the "Diabetes Plan of Care" dated 9/16, updated last 12/5/11, indicated, "...Administer insulin per MD order..." During interview on 12/12/11 at 9:30 A.M., the ADON indicated the facility did a 100 % audit of the sliding scale blood sugars when it was identified during the survey that there was still an issue with sliding scale errors. She further indicated the facility system that was in place was broken and didn't fully identify the problems. 3. The clinical record for Resident # 1 reviewed on 12/5/11 at 3:00 P.M., indicated diagnoses of, but not limited to: anemia,hemiplegia, and arthritis. Review of a "Physician's Order" dated 10/19/11, indicated, "...Aranesp (medication used to treat anemia - a low			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	hemoglobin level) 60 mcg (micrograms)/0.3 ml (milliliters)...inject 0.3 ml sub q (injection) every week if HGB (hemoglobin) < 10..." Review of the November 2011, MAR, indicated Resident # 1's 11/25/11 Hemoglobin was 10.0. The MAR further indicated Resident # 1 received an Aranesp injection on 11/25/11. During interview with the ADON on 12/5/11 at 4:00 P.M., she indicated Resident # 1 did receive an Aranesp injection on 11/25/11. She further indicated Resident # 1 should not have received the injection based on the order because her Hemoglobin level was not less than 10.0. 3.1-25(b)(9)			
F0371 SS=F	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to ensure the food preparation areas were clean and sanitary related to the lack of proper utilization of	F0371	F371It is the practice of this facility to store, prepare, distribute and serve food under sanitary conditions.CORRECTIVE ACTION: Staff in-serviced on proper use of hairnets and beard	01/09/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	hair nets and beard protectors by all staff while serving meals. This deficient practice had the potential to effect 72 of 73 residents who receive meals prepared in 1 of 1 facility kitchen. Findings include: On 12/5/11 at 5:20 p.m. a total of 8 employees (Registered Dietician #21, ADON, CNA #22, Dietary Aide #23, CNA #24, CNA #25, Unit Manager #28, and Unit Manager #29) were observed entering the kitchen and leaving the designated area that does not require hair nets. The 8 employees were observed directly in front of the serving area and reaching over the serving area. Dietary Aide #26 and Dietary Aide #27 were observed working in the kitchen and entering/exiting during meal serving without a beard protector. During interview on 12/5/11 at 5:35 p.m., Dietary Manager #30 indicated staff is permitted to enter the kitchen in the designated area only without hair nets. He included they may reach from the designated area to take a plate but should not be leaning/standing on or next to the serving area. Interview on 12/5/11 at 5:42 p.m., Registered Dietician # 21 indicated		protectors while in kitchen area.HOW OTHERS IDENTIFIED: Residents residing in the facility will be addressed by in-servicing staff on proper use of hairnets and beard protectors.PREVENTATIVE MEASURES: Staff entering the kitchen will be monitored for proper use of hairnets and beard protectors through observation. ADDENDUM ADDED 1/4/12MONITORING: All 3 meals to be monitored by CDM and/or desginee daily for 2 weeks, 3 times a week for 8 weeks, weekly for 8 weeks, and monthly for 3 months. Findings will be reviewed at monthy QPI meeting.Any deficient practice will be addressed through staff education, in-service, and/or counseling.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Dietary Aide #26 and Dietary Aide #27 should have had beard protectors on. She further indicated she was going to have them put them on right away. 3.1-21(i)(1)			
F0385 SS=D	A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable. Based on interview and record review, the facility failed to ensure a resident's medical care was supervised by a physician related to pain medication for 1 of 9 residents reviewed for pain in a sample of 15. [Resident #40] Findings include: The clinical record of Resident #40 was reviewed on 12/06/2011 at 11:03 a.m. Resident #40's diagnoses include, but were not limited to, HTN (hypertension), COPD (Chronic Obstructive Pulmonary Disease), right sided heart failure, infected Stage III and unstageable pressure sores, rhadomyolysis, and chronic Cor	F0385	F385It is the practice of this facility that the medical care of each resident is supervised by a physician; and another physician supervises medical care of residents when their attending physician is unavailable.CORRECTIVE ACTION: Resident # 40 - Resident has current order for routine and prn pain medication.Written notice sent to physician/Medical Director regarding responsibilities for pain management of residents. In the event the nursing staff get an inappropriate response from physician related to resident orders the nurse is to call Administrator and/or D.O.N. immediately. Administrator	01/09/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Pulmonale. A "Physician's Orders" dated 10/31/11 indicated, "...Hydrocodone-APAP 5-325 Take 2 PO (by mouth) Q6 (every 6 hours) for pain PRN (as needed)...." The "Medication Administration Record" dated 11/1/11 through 11/10/11 indicated Resident #46 requested the hydrocodone-APAP PRN medication 22 times out of an available 40 doses. A "Physician's Orders" dated 11/11/11 indicated, "...Hydrocodone APAP 5-325 mg IC: Norco 5-325 Tablet...Give 2 tablets orally every 6 hours as needed for pain...." The "Medication Administration Record" dated 11/11/11 through 11/24/11 indicated Resident #46 requested the hydrocodone-APAP PRN medication 35 times out of an available 56 doses. A "Physician's Orders" dated 11/22/11 indicated a change from PRN (as needed) to a scheduled routine order, "...Hydrocodone 5/325 2 po (by mouth) q6 (every 6 hours)...." On the back of the "Medication Administration Record" in the "Nurses PRN Notes" dated 11/29/11 at 6 p.m.		and/or D.O.N. will contact physician/Medical Director. In the event Adminstrator and/or D.O.N. are unable to get resolution the resident will be sent to the E.R. for evaluation and treatment.HOW OTHERS IDENTIFIED: Residents residing in the facilty will be addressed by notification sent to physician/Medical Director.PREVENTATIVE MEASURES: A.D.O.N. and/or designee will review prn medication logs on Thursday of each week to check the current availability and the amount of medication on hand against the possible need and will obtain order from physician on Fridays during rounds to prevent exhausting supply on weekends.MONITORING: A.D.O.N. and/or designee will monitor the pain medication logs to ensure medication is available. Medication logs will be monitored daily for 2 weeks, 3 times a week for 8 weeks, weekly for 8 weeks, and monthly for 3 months. All findings will be reviewed at monthly QPI meeting.Any deficient practice will be addressed through staff education, in-service, and/or counseling.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	"...Norco 5-325 out of stock and no order to get in EDK due to no faxed signature for Dr. (Name)...." On the back of the "Medication Administration Record" in the "Nurses PRN Notes" dated 11/30/11 at 12 a.m. "...Vicodin not available...." The "Medication Administration Record" dated 11/30/11 indicated the next dose of Hydrocodone APAP 5-325 was given at 12:00 p.m. A "Nursing Note" dated 11/29/11 at 6:00 p.m. indicated, "No Norco in stock for resident. Called (Pharmacy Name). They stated they faxed two papers to Dr. (Name)'s office to get a signed order but no response from him." A "Nursing Note" dated 11/29/11 at 7:00 p.m. indicated, "Phoned Dr. (Name) asked him for an order for Norco he stated "no he was not doing it tonight" I stated resident was completely out of pain meds. He said it will wait until morning. I then informed resident." During and interview on 12/5/11 at 5:00 p.m. with Unit Manager #28 she indicated that according to the "Medication Administration Record," Resident #46 was out of her pain medication,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Hydrocodone APAP 5-325, from 11/29/11 at 12:00 p.m. until 11/30/11 at 6:00 p.m. for approximately 30 hours. During an interview with Resident #46 on 12/6/11 at 4:35 p.m. she indicated that she was concerned about getting medication refills from her physician while in the facility. She indicated that this is not the first time she has had to wait over 24 for a refill on a medication at this facility. She specifically remembers this time due to it being her pain medication. She indicated that she did take her PRN (as needed) medication, Tylenol, but felt that she has better pain control when she had her Norco. She included that she is upset due to Social Services telling her that her expectations of her physician were not reasonable. 3.1-22(a)(1) 3.1-22(a)(2)			
F0389 SS=D	The facility must provide or arrange for the provision of physician services 24 hours a day, in case of an emergency. Based on interview and record review, the facility failed to ensure emergency physician services were available 24 hours per day for 1 of 15 residents reviewed for proper medical care in a sample of 15. [Resident # 40]	F0389	F389It is the practice of this facility to provide or arrange for the provision of Physicain Services 24 hours a day, in case of emergency. CORRECTIVE ACTION: Resident # 40 - Resident has current order for routine and prn pain medication.Written notice sent	01/09/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: The clinical record of Resident #40 was reviewed on 12/06/2011 at 11:03 a.m. Resident #40's diagnoses include, but were not limited to, HTN (hypertension), COPD (Chronic Obstructive Pulmonary Disease), right sided heart failure, infected Stage III and unstageable pressure sores, rhadomyolysis, and chronic Cor Pulmonale. A "Physician's Orders" dated 10/31/11 indicated, "...Hydrocodone-APAP 5-325 Take 2 PO (by mouth) Q6 (every 6 hours) for pain PRN (as needed)...." The "Medication Administration Record" dated 11/1/11 through 11/10/11 indicated Resident #40 requested the hydrocodone-APAP PRN medication 22 times out of an available 40 doses. A "Physician's Orders" dated 11/11/11 indicated, "...Hydrocodone APAP 5-325 mg IC: Norco 5-325 Tablet...Give 2 tablets orally every 6 hours as needed for pain...." The "Medication Administration Record" dated 11/11/11 through 11/24/11 indicated Resident #40 requested the hydrocodone-APAP PRN medication 35 times out of an available 56 doses.		to physician/Medical Director regarding responsibilities for pain management of residents. In the event the nursing staff get an inappropriate response from physician related to resident orders the nurse is to call Administrator and/or D.O.N. immediately. Administrator and/or D.O.N. will contact physician/Medical Director. In the event Adminstrator and/or D.O.N. are unable to get resolution the resident will be sent to the E.R. for evaluation and treatment.HOW OTHERS IDENTIFIED: Residents residing in the facilty will be addressed by notification sent to physician/Medical Director.PREVENTATIVE MEASURES: A.D.O.N. and/or designee will review prn medication logs on Thursday of each week to check the current availability and the amount of medication on hand against the possible need and will obtain order from physician on Fridays during rounds to prevent exhausting supply on weekends.MONITORING: A.D.O.N. and/or designee will monitor the pain medication logs to ensure medication is available. Medication logs will be monitored daily for 2 weeks, 3 times a week for 8 weeks, weekly for 8 weeks, and monthly for 3 months. All findings will be reviewed at monthly QPI meeting.Any deficient practice will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A "Physician's Orders" dated 11/22/11 indicated a change from PRN (as needed) to a scheduled routine order, "...Hydrocodone 5/325 2 po (by mouth) q6 (every 6 hours)...." On the back of the "Medication Administration Record" in the "Nurses PRN Notes" dated 11/29/11 at 6 p.m. "...Norco 5-325 out of stock and no order to get in EDK due to no faxed signature for Dr. (Name)...." On the back of the "Medication Administration Record" in the "Nurses PRN Notes" dated 11/30/11 at 12 a.m. "...Vicodin not available...." The "Medication Administration Record" dated 11/30/11 indicated the next dose of Hydrocodone APAP 5-325 was given at 12:00 p.m. A "Nursing Note" dated 11/29/11 at 6:00 p.m. indicated, "No Norco in stock for resident. Called (Pharmacy Name). They stated they faxed two papers to Dr. (Name)'s office to get a signed order but no response from him." A "Nursing Note" dated 11/29/11 at 7:00 p.m. indicated, "Phoned Dr. (Name) asked him for an order for Norco he stated "no		addressed through staff education, in-service, and/or counseling.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	he was not doing it tonight" I stated resident was completely out of pain meds. He said it will wait until morning. I then informed resident." During and interview on 12/5/11 at 5:00 p.m. with Unit Manager #28 she indicated that according to the "Medication Administration Record," Resident #40 was out of her pain medication, Hydrocodone APAP 5-325, from 11/29/11 at 12:00 p.m. until 11/30/11 at 6:00 p.m. for approximately 30 hours. During an interview with Resident #40 on 12/6/11 at 4:35 p.m. she indicated that she was concerned about getting medication refills from her physician while in the facility. She indicated that this is not the first time she has had to wait over 24 for a refill on a medication at this facility. She specifically remembers this time due to it being her pain medication. She indicated that she did take her PRN (as needed) medication, Tylenol, but felt that she has better pain control when she had her Norco. She included that she is upset due to Social Services telling her that her expectations of her physician were not reasonable. 3.1-22(e)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0490 SS=D	A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on interview and record review, the facility failed to ensure the Administrator guaranteed uninterrupted medical care for 1 of 15 residents reviewed for proper medical care in a sample of 15. [Resident # 40] Findings include: The clinical record of Resident #40 was reviewed on 12/06/2011 at 11:03 a.m. Resident #40's diagnoses include, but were not limited to, HTN (hypertension), COPD (Chronic Obstructive Pulmonary Disease), right sided heart failure, infected Stage III and unstageable pressure sores, rhadomyolysis, and chronic Cor Pulmonale. A "Physician's Orders" dated 10/31/11 indicated, "...Hydrocodone-APAP 5-325 Take 2 PO (by mouth) Q6 (every 6 hours) for pain PRN (as needed)...." The "Medication Administration Record" dated 11/1/11 through 11/10/11 indicated Resident #40 requested the hydrocodone-APAP PRN medication 22 times out of an available 40 doses.	F0490	F490It is the practice of this facility to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.CORRECTIVE ACTION: Resident # 40 - Resident has current order for routine and prn pain medication.Written notice sent to physician/Medical Director regarding responsibilities for pain management of residents. In the event the nursing staff get an inappropriate response from physician related to resident orders the nurse is to call Administrator and/or D.O.N. immediately. Administrator and/or D.O.N. will contact physician/Medical Director. In the event Adminstrator and/or D.O.N. are unable to get resolution the resident will be sent to the E.R. for evaluation and treatment.HOW OTHERS IDENTIFIED: Residents residing in the facilty will be addressed by notification sent to physician/Medical Director.PREVENTATIVE MEASURES: A.D.O.N. and/or designee will review prn medication logs on Thursday of each week to check the current availability and the amount of	01/09/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A "Physician's Orders" dated 11/11/11 indicated, "...Hydrocodone APAP 5-325 mg IC: Norco 5-325 Tablet...Give 2 tablets orally every 6 hours as needed for pain...." The "Medication Administration Record" dated 11/11/11 through 11/24/11 indicated Resident #40 requested the hydrocodone-APAP PRN medication 35 times out of an available 56 doses. A "Physician's Orders" dated 11/22/11 indicated a change from PRN (as needed) to a scheduled routine order, "...Hydrocodone 5/325 2 po (by mouth) q6 (every 6 hours)...." On the back of the "Medication Administration Record" in the "Nurses PRN Notes" dated 11/29/11 at 6 p.m. "...Norco 5-325 out of stock and no order to get in EDK due to no faxed signature for Dr. (Name)...." On the back of the "Medication Administration Record" in the "Nurses PRN Notes" dated 11/30/11 at 12 a.m. "...Vicodin not available...." The "Medication Administration Record" dated 11/30/11 indicated the next dose of Hydrocodone APAP 5-325 was given at		medication on hand against the possible need and will obtain order from physician on Fridays during rounds to prevent exhausting supply on weekends.MONITORING: A.D.O.N. and/or designee will monitor the pain medication logs to ensure medication is available. Medication logs will be monitored daily for 2 weeks, 3 times a week for 8 weeks, weekly for 8 weeks, and monthly for 3 months. All findings will be reviewed at monthly QPI meeting.Any deficient practice will be addressed through staff education, in-service, and/or counseling.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	12:00 p.m. A "Nursing Note" dated 11/29/11 at 6:00 p.m. indicated, "No Norco in stock for resident. Called (Pharmacy Name). They stated they faxed two papers to Dr. (Name)'s office to get a signed order but no response from him." A "Nursing Note" dated 11/29/11 at 7:00 p.m. indicated, "Phoned Dr. (Name) asked him for an order for Norco he stated "no he was not doing it tonight" I stated resident was completely out of pain meds. He said it will wait until morning. I then informed resident." The clinical record lacked documentation of the Administrator being notified of the physician refusing to refill Resident # 40's pain medication at the of the request. During and interview on 12/5/11 at 5:00 p.m. with Unit Manager #28 she indicated that according to the "Medication Administration Record," Resident #40 was out of her pain medication, Hydrocodone APAP 5-325, from 11/29/11 at 12:00 p.m. until 11/30/11 at 6:00 p.m. for approximately 30 hours. During an interview with Resident #40 on 12/6/11 at 4:35 p.m. she indicated that she was concerned about getting medication			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	refills from her physician while in the facility. She indicated that this is not the first time she has had to wait over 24 for a refill on a medication at this facility. She specifically remembers this time due to it being her pain medication. She indicated that she did take her PRN (as needed) medication, Tylenol, but felt that she has better pain control when she had her Norco. She included that she is upset due to Social Services telling her that her expectations of her physician were not reasonable. 3.1-13(q)			
F0501 SS=D	The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility. Based on interview and record review, the facility failed to ensure the medical director coordinated all aspects of a residents medical care for 1 of 15 residents reviewed for proper medical care in a sample of 15. Resident # 40 Findings include:	F0501	F501It is the practice of this facility for the Medical Director to be responsible for implementation of resident care policies; and the coordination of medical care in the facility. CORRECTIVE ACTION: Resident # 40 - Resident has current order for routine and prn pain medication.Written notice sent to physician/Medical Director regarding responsibilities for pain management of residents. In the event the nursing staff get an	01/09/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The clinical record of Resident #40 was reviewed on 12/06/2011 at 11:03 a.m. Resident #40's diagnoses include, but were not limited to, HTN (hypertension), COPD (Chronic Obstructive Pulmonary Disease), right sided heart failure, infected Stage III and unstageable pressure sores, rhadomyolysis, and chronic Cor Pulmonale. A "Physician's Orders" dated 10/31/11 indicated, "...Hydrocodone-APAP 5-325 Take 2 PO (by mouth) Q6 (every 6 hours) for pain PRN (as needed)...." The "Medication Administration Record" dated 11/1/11 through 11/10/11 indicated Resident #40 requested the hydrocodone-APAP PRN medication 22 times out of an available 40 doses. A "Physician's Orders" dated 11/11/11 indicated, "...Hydrocodone APAP 5-325 mg IC: Norco 5-325 Tablet...Give 2 tablets orally every 6 hours as needed for pain...." The "Medication Administration Record" dated 11/11/11 through 11/24/11 indicated Resident #40 requested the hydrocodone-APAP PRN medication 35 times out of an available 56 doses. A "Physician's Orders" dated 11/22/11		inappropriate response from physician related to resident orders the nurse is to call Administrator and/or D.O.N. immediately. Administrator and/or D.O.N. will contact physician/Medical Director. In the event Adminstrator and/or D.O.N. are unable to get resolution the resident will be sent to the E.R. for evaluation and treatment.HOW OTHERS IDENTIFIED: Residents residing in the facilty will be addressed by notification sent to physician/Medical Director.PREVENTATIVE MEASURES: A.D.O.N. and/or designee will review prn medication logs on Thursday of each week to check the current availability and the amount of medication on hand against the possible need and will obtain order from physician on Fridays during rounds to prevent exhausting supply on weekends.MONITORING: A.D.O.N. and/or designee will monitor the pain medication logs to ensure medication is available. Medication logs will be monitored daily for 2 weeks, 3 times a week for 8 weeks, weekly for 8 weeks, and monthly for 3 months. All findings will be reviewed at monthly QPI meeting.Any deficient practice will be addressed through staff education, in-service, and/or counseling.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated a change from PRN (as needed) to a scheduled routine order, "...Hydrocodone 5/325 2 po (by mouth) q6 (every 6 hours)...." On the back of the "Medication Administration Record" in the "Nurses PRN Notes" dated 11/29/11 at 6 p.m. "...Norco 5-325 out of stock and no order to get in EDK due to no faxed signature for Dr. (Name)...." On the back of the "Medication Administration Record" in the "Nurses PRN Notes" dated 11/30/11 at 12 a.m. "...Vicodin not available...." The "Medication Administration Record" dated 11/30/11 indicated the next dose of Hydrocodone APAP 5-325 was given at 12:00 p.m. A "Nursing Note" dated 11/29/11 at 6:00 p.m. indicated, "No Norco in stock for resident. Called (Pharmacy Name). They stated they faxed two papers to [resident's primary care physician/also facility Medical Director] Dr. (Name)'s office to get a signed order but no response from him." A "Nursing Note" dated 11/29/11 at 7:00 p.m. indicated, "Phoned Dr. (Name) [resident's primary care physician/also			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	facility Medical Director] asked him for an order for Norco he stated "no he was not doing it tonight" I stated resident was completely out of pain meds. He said it will wait until morning. I then informed resident." During and interview on 12/5/11 at 5:00 p.m. with Unit Manager #28 she indicated that according to the "Medication Administration Record," Resident #40 was out of her pain medication, Hydrocodone APAP 5-325, from 11/29/11 at 12:00 p.m. until 11/30/11 at 6:00 p.m. for approximately 30 hours. During an interview with Resident #40 on 12/6/11 at 4:35 p.m. she indicated that she was concerned about getting medication refills from her physician while in the facility. She indicated that this is not the first time she has had to wait over 24 for a refill on a medication at this facility. She specifically remembers this time due to it being her pain medication. She indicated that she did take her PRN (as needed) medication, Tylenol, but felt that she has better pain control when she had her Norco. She included that she is upset due to Social Services telling her that her expectations of her physician were not reasonable. 3.1-13(v)(4)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE